**BEFORE THE ARIZONA MEDICAL BOARD**

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| In the Matter of<br><br>**JERI B. HASSMAN, M.D.**<br><br>Holder of License No. **16132**<br>For the Practice of Allopathic Medicine<br>In the State of Arizona. | Board Case No. MD-05-0151A<br><br>**FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER**<br><br>(Letter of Reprimand and Probation) |

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 6, 2006. Jeri B. Hassman, M.D., ("Respondent") appeared before the Board for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

## FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 16132 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-05-0151A after completing a chart review pursuant to the terms of a 2004 Board Order for a Decree of Censure and Probation. After reviewing the records a Board Medical Consultant opined that Respondent fell below the standard of care by not documenting the amount of corticosteroids injected during joint and soft tissue injections, by not examining joint or soft tissue areas before injecting patient CS on several occasions, and for doing excessive joint and soft tissue injections. The Medical Consultant also opined that Respondent fell below the standard of care when she gave patient SG multiple NSAID samples to use at the same time, but did not document instructions on how to take the medication in her treatment plan.

4. Respondent testified she gave SG NSAIDs in December of 2003 when SG had been on both Celebrex and Vioxx prior to that. Respondent testified the sample boxes contained two pills of Vioxx and three Celebrex and SG was well aware she was supposed to take one per day because she had been on the medications before. Respondent testified CS was a very complicated patient with multiple medical problems who was referred to her by a primary care physician for treatment of reflex sympathetic dystrophy ("RSD"), or complex regional pain syndrome. Respondent testified CS was referred for the purpose of giving multiple injections, joint injections and soft tissue injections, to decrease pain. Respondent testified the primary care physician was well aware of the treatment CS was getting and that the injections contain very dilute, very small amounts of corticosteroids. Respondent maintained that CS suffered no harm. Respondent explained that each injection in CS's shoulder contained no more than .2 milligrams of Dexamethasone and there were a total of seventeen injections for a total of 3.4 milligrams of corticosteroid. Respondent testified an article from *Postgraduate Medicine* states three to four injections per year of about four milligrams is acceptable and Respondent injected less than that. Respondent testified she examined the joints on more occasions than the Medical Consultant reported, she saw CS very frequently, and examined each joint at least three times per month. Respondent testified she corrected her documentation of the actual dose when it was pointed out to her that it was required.

5. The Board directed Respondent to her record for patient SC, starting with the visit on March 15, 2004, specifically the note that Respondent administered multiple trigger point injections in the scalp bilateral, cervical paraspinals, bilateral supraspinatus, bilateral thoracic etc, with one percent Lidocaine under sterile conditions and applying direct pressure. The Board asked if it was a reasonable standard to document the total amount of Lidocaine used in all these injections and the number of injections done. Respondent testified this could be added, but most people know a trigger point injection into the upper trapezius muscle consists of a volume of one

half to one CC. Respondent acknowledged she could have added the total volume was twenty CCs. The Board asked if Respondent was saying her practice was to drop a twenty CC syringe of one percent Lidocaine to inject multiple trigger points. Respondent testified she was not and she meant to say ten CCs in the upper body. The Board noted this illustrated that the record does not tell how much she injected.

6. The Board asked how much SC weighed and the maximum dose of Lidocaine based on her weight. Respondent testified SC weighed about 150 – 160 pounds and would probably get light-headed at thirty CCs. The Board asked how many milligrams that would be. Respondent testified she did not know the milligrams per mil of Lidocaine. The Board informed Respondent it is one percent. The Board asked if it was plain Lidocaine or did it have epinephrine in it. Respondent testified it was plain. The Board asked if epinephrine would make a difference, and if so, how. Respondent testified it would have a cardiac effect. The Board asked if it would have any effect on the dose given. Respondent testified if there was epinephrine it would certainly have an effect and it is used in limited circumstances for a particular effect. She noted she would have no reason to add epinephrine to trigger point injections for myofacial pain. The Board asked if it is standard of care in Respondent's specialty to document the amount of medication injected. Respondent testified her answer now would be yes. The Board confirmed Respondent had changed her practice and was now documenting the amount.

7. The Board directed Respondent to the April 30 visit with CS where Respondent describes what is going on with CS, does a limited physical examination, and injects one percent Lidocaine. The Board asked if the same problem of not noting the amount existed on this visit as well. Respondent testified it did. The Board directed Respondent to the May 14 visit where there is note of a visit, a history, and multiple trigger point injections of one percent Lidocaine and Dexamethasone. The Board asked what Respondent's practice was in terms of adding Dexamethasone to the injections. Respondent testified at that time she had only done it three

times and she added one half CC of Dexamethasone and the concentration of that is four milligrams per mil, for a total of 9.5 CCs of Lidocaine and two milligrams of Dexamethasone. The Board asked Respondent if it was correct that when she was doing multiple injections of a steroid like Dexamethasone there is adrenal suppression. Respondent testified there can be with a high dose on a sustained amount of time daily or at least regular injections, but as far as sporadic injections, she thinks the risk is minimal. The Board noted the risk is minimal depending on the dose injected and that another physician would not be able to tell, from Respondent's chart, the amount injected. Respondent agreed and noted she changed her practice as soon as it was pointed out to her.

8. The Board directed Respondent to patient CS, specifically the chart prepared by its Medical Consultant of the injections Respondent gave CS, and confirmed she agreed with the dates of service and injections noted. The Board directed Respondent to the March 19 visit, after the Decree of Censure was issued to Respondent in the earlier case, where Respondent injected CS's right shoulder. The Board noted the shoulder was injected on March 1, 24, 26, 31, April 5, and 9. The Board asked how six injections in a period of three weeks complied with the standard of care articulated by the Medical Consultant and alluded to by Respondent of four times per year for large joint injections. Respondent testified the standard articulated by the Medical Consultant and referred to by her refers to an injection that contains significantly more corticosteroid than she injected and they use triamcinolone, not Dexamethasone. Respondent noted each injection would contain thirty milligrams of triamcinolone at four times per year would be 120 milligrams of triamcinolone over the year. Respondent noted converting that to Dexamethasone potency, dividing it by five, results in twenty-four milligrams of Dexamethasone into the shoulder joint per year. Respondent testified the recommendation of four times per year is based on the dose of corticosteroid and, if the injection did not contain any corticosteroid, there would not be any limit.

The Board asked if there was any particular reason Respondent used Dexamethasone instead of triamcinolone. Respondent testified there was not.

9. The Board asked what type of Dexamethasone injection she was using for these injections. Respondent testified she thought it was Dexamethasone phosphate at a concentration of four milligrams per mil. The Board asked if there was more than one type in terms of their duration of action. Respondent testified Dexamethasone phosphate is considered long duration and there might be another kind, but she could not say what the salt would be. Respondent testified she could not offhand tell the Board exactly all the differences between all the types of corticosteroids. The Board asked how much Dexamethasone she was injecting into CS on March 19, 2004 when she did right shoulder multiple trigger points and right-sided back with Marcaine and Dexamethasone. Respondent testified it would be a total of two milligrams of Dexamethasone in all of the injections. The Board noted Respondent was now using Marcaine and Dexamethasone instead of Lidocaine and asked what the mixture was. Respondent testified it was 19.5 CCs of .5 Marcaine and the same two milligrams per mil of Dexamethasone, or half a CC of it in a twenty CC syringe. The Board asked how many trigger points Respondent injected on that date. Respondent testified it was between eight and ten and they are documented.

10. The Board referred to Respondent's earlier statement that there was no potential harm from the shoulder injections and asked Respondent the possible known complications of injecting the right shoulder. Respondent testified there is always an inherent risk of bleeding or infection any time a shoulder is injected; a risk you minimize by using proper sterile technique, sterile equipment, and Betadine over the shoulder. The Board asked if Respondent's interpretation of the standard of care was that she met the standard as long as she did not exceed a total of sixteen milligrams of Dexamethsone into the shoulder. Respondent testified she was saying that with CS, a very complicated, sick patient with severe chronic pain on a high dose of opioids who was waiting for cervical sympathectomy among other problems, the management

was justified and the frequency of injections was justified as long as the dose of corticosteroid was low. Respondent testified it was not her practice to inject a shoulder sixteen times and with no other patient did this occur, but with CS's medical condition, what she was trying to accomplish, that her primary care doctor agreed with this and authorized the treatment, there was no actual or potential harm and the treatment helped more than hurt the patient. Respondent testified CS was at high risk for frozen shoulder and all the complications of immobilization of joints and those consequences were worse than the theoretical risk of continuous injections. Respondent testified she was not saying it was standard of care to do this, but with CS it was indicated. The Board asked if ten, fifteen, or twenty shoulder injections over a period of several months increased her risk of intra-articular infection – a significant problem if it occurs. Respondent testified the risk of intra-articular infection was less than the risk of frozen shoulder because there is no question CS would have gotten that if she did not get these injections to maintain the range of motion of the shoulder.

11. The Board asked Respondent if she thought if she followed the standard procedure and injected the shoulder with four milligrams of Dexamethasone and some Lidocaine that she may have had a better result rather than the microdose she was using on several occasions. Respondent testified she did not because CS's condition was not inflammatory and she was not giving the injections to deliver a therapeutic dose of a corticosteroid on anti-inflammatory medication. Respondent noted the injections could have contained pure Lidocaine and the only reason she added Dexamethasone was not to deliver a therapeutic dose, but because she noticed the local anesthetic effect of Lidocaine or Marcaine lasts longer when she adds a corticosteroid. The Board asked why CS had shoulder pain. Respondent testified CS had RSD and the Lidocaine helped her to maintain range of motion of her shoulder. Respondent noted a big concern was frozen shoulder, which CS almost had fifteen years earlier when she had her first episode of RSD and was treated with a partial sympathectomy. The Board noted it

recognized RSD patients are very, very difficult, but asked if part of the standard of care of treating RSD patients was to give injections of Lidocaine or Marcaine into a joint twice per week for a period of time to avoid frozen shoulder – was this in the literature. Respondent testified it was not in the literature, but she had treated CS in this way fifteen years earlier and was successful and CS did well until the motor vehicle accident. Respondent noted there was nothing in the literature that said she could not do this.

12. The Board asked what other modalities Respondent was using to try to improve the frozen shoulder. Respondent testified CS was given ultrasound of the trapezius muscles and to the shoulder and range of motion exercises after treatment, was on a high dose of opioids from her primary care doctor to help her with mobilization, and she also got sympathetic blocks. The Board directed Respondent back to the dosage of Dexamethasone given and asked if she gave two milligrams in each shoulder. Respondent testified she gave two milligrams per twenty CCs – two milligrams in a 20 CC syringe and the shoulder received two CCs of that solution, which yielded .2 milligrams of Dexamethasone per injection. The Board asked if Respondent used the same syringe and needle for each area. Respondent testified she used the same syringe, but changed the needle. The Board asked if Respondent was concerned about withdrawing anything into the syringe when she went into a joint. Respondent testified she did not aspirate the joint. The Board noted she would not need to aspirate the joint because there was enough pressure in the joint to get back some fluid in the syringe. Respondent testified she injected the shoulder first and the elbow and she was mainly going into soft tissues. The Board noted the joint is very superficial and even if she went into soft tissue she could easily go into the joint. The Board noted Respondent could get fluid back into the syringe itself and this was a very poor technique for injecting shoulder joints.

13. The Board asked the duration of CS's pain relief if Respondent gave just Lidocaine and no steroids. Respondent testified the relief would last for a day or two. The Board noted it

was then conceivable that CS could come to Respondent every other day for an injection to keep her relatively pain free. Respondent agreed that could happen. The Board noted its confusion as to why Respondent would do a procedure whose effect lasted such a short length of time. Respondent testified CS felt better for three to five days as a result of the injection and it was part of her pain management program. The Board asked the side effect of Lidocaine. Respondent testified long-term there was little or none. The Board asked about cardiac effects. Respondent testified there could be cardiac effects if the dose was high enough, but she did not think she ever achieved that high an amount and CS did not have cardiac symptoms. The Board asked if Respondent ever did an EKG to see what was happening with CS's PRS or her PR interval. Respondent testified she did not give an EKG around her injections, but CS had them in pre-operative testing and had them after.

14. The Board asked Respondent if she obtained informed consent from CS. Respondent testified there were informed consents to treat – a general consent and she did not obtain one each time she gave injections. The Board asked how Respondent counseled CS in getting informed consent – what would she tell her was the proposed benefit of the injections. Respondent testified she would tell CS about pain relief and increasing range of motion of the joint. The Board asked if Respondent told CS she was giving her a corticosteroid injection or a Lidocaine injection. Respondent testified CS knew exactly what she was getting. The Board asked what CS's expectations were of the injection based on the informed consent. Respondent testified the CS expected local anesthetic relief and better range of motion. Respondent testified it was CS's decision to come in and get the injections and the injections were supposed to be until she could get the sympathectomy performed.

15. The Board asked Respondent to describe the procedure of doing the injection, including where she puts the needle and how she know she is in the joint. Respondent testified she uses a posterior, just inferior to the spine of the scapula, approach with a twenty-five gauge

needle. Respondent testified she palpates the glenohumeral space below the spine of the scapula and she goes in at pretty much a forty-five degree angle toward the head. Respondent testified if she is injecting the right shoulder she is going in at forty-five degrees toward the patient's chin, but she is in the back. Respondent testified if she does not hit any bone or anything firm then she knows she has to be in the joint. The Board asked if Respondent had to use a moderate amount of force. Respondent testified she did not and used very easy force.

15. The Board confirmed Respondent was confident by her description that she was in the glenohumeral joint. The Board suggested Respondent was actually in the subacromial space, not the glenohumeral joint. Respondent testified the subacromial space works for her if that would help provide pain relief. The Board asked whether she was injecting the joint or into the subacromial space. Respondent testified she palpates the space between the humerus and the glenoid and she thinks she is feeling it and she is going in that space at an angle anterior and midline, toward the midline. Respondent testified the subacromial is much more anterior and she did not see how she could be in that space. The Board asked Respondent what structures are between the skin and the glenohumeral joint going from posterior to anterior. Respondent testified she thought that she went through the glenohumeral joint, through the labrum and then she is in the joint. The Board asked if it was Respondent's testimony that immediately after the skin she was in the glenohumeral joint. Respondent testified she may be going through the labrum, and maybe supraspinatus muscle. The Board noted it was asking which structures are going from the skin to the joint and beyond the joint. Respondent testified there was skin and supraspinatus muscle and glenoid labrum and them glenohumeral joint, but the needle is not long enough to go any further than that. The Board asked where she would encounter the teres minor. Respondent testified it might go through the teres minor and the supraspinatus. The Board asked if she would encounter the subscapularis. Respondent testified she did not think so

because it would be more anterior, or more inferior. The Board confirmed Respondent maintained her injections were in the shoulder joint.

16. The Board asked Respondent what she understood as the maximum allowable dosage of one percent Xylocaine plain – how many milligrams per kilogram before toxicity. Respondent testified at thirty CCs of one percent Lidocaine the patient would feel light-headed and that would be one percent. The Board asked how much Lidocaine she would give an average 180 pound male. Respondent testified she thought it would be safe to give 10 CCs of one percent Lidocaine. The Board noted it believed the amount was higher. The Board asked how it would affect things if it were one percent Xylocaine with epinephrine. Respondent testified it would depend on the concentration of epinephrine and she thinks there are a couple of formulations. The Board asked Respondent to assume the standard one to 100,000. Respondent testified she almost never uses it and would say it is much less. Respondent testified she had no indication to use epinephrine because she does not want the Lidocaine to stay localized and it would be counterproductive to use it. Respondent testified she could not intelligently tell the Board the maximum dose of Lidocaine with epinephrine because she never uses it. The Board asked Respondent to just give a number and a range of how many milligrams per kilogram of one percent Xylocaine plain she can safely give a patient. Respondent testified she only knows volume of one percent Lidocaine and does not know milligram per milliliter, but up to twenty or twenty-five CCs of one percent Lidocaine would be the maximum she would give at one time. The Board confirmed Respondent did not know the maximum allowable dosage.

17. The Board asked Respondent how many milligrams per CC there is in one percent Lidocaine. Respondent testified she did not know because she does not talk about it in terms of milligrams per mil and has never discussed it that way. Respondent testified she was not giving a therapeutic dose of Lidocaine and was not delivering it for any cardiac effects. Respondent testified she did not see much of a difference between knowing the percentage of the solution

and knowing the milligram per CC. The Board asked Respondent if she should know the toxic range – the maximum dose so she could stay within the safe range. Respondent testified she did know that, but it is not based in terms of milligrams per CC it is based on the amount or volume or CCs of a one percent solution.

18. The Board noted that doing a shoulder injection not under ultrasound or fluoroscopy is basically a blind shoulder injection that is not anywhere where it seems to be and that Respondent is probably not getting in the joint most of the time she thinks she is. The Board asked if it was a consideration that if Respondent was not certain she is in the joint she should not inject because the needle may be in a tendon and might cause harm or atrophy of the rotator cuff. Respondent testified it was a consideration and she certainly did not want to inject the rotator cuff. The Board asked how she made sure she did not. Respondent testified the injection is very easy and she can feel that she is not injecting a ligament or tendon because they are a lot firmer.

19. The standard of care required Respondent to document the total quantity of steroids injected into patients on each visit, to be aware of the limits and toxic effects of the medications she was using, to know in detail the anatomy of the area she was injecting, and to not inject steroids more often than every three to four months.

20. Respondent failed to document the total quantity of steroids injected into patients on each visit, was not aware of the limits and toxic effects of the medications she was using, did not know in detail the anatomy of the area she was injecting, and injected steroids more often than every three to four months.

21. Patients were subject to potential harm of misdiagnosis and treatment for conditions that may not have been present, and, because there are no documented Dexamethasone doses for each procedure, the potential harm of risk of adrenal suppression and

side effects from excessive steroid use, soft tissue atrophy at injection sites, and steroid arthropathy with potential cartilage damage.

## CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. §§ 32-1401(27)(e) ("[f]ailing or refusing to maintain adequate records on a patient"); and 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public").

## ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for excessive joint and soft tissue injections without adequate indications and for inadequate documentation of the quantities of pharmaceuticals injected.

2. Respondent is placed on probation for two years with the following terms and conditions:

a. Respondent's practice is restricted in that she shall not perform joint and soft tissue injections. Respondent may petition the Board to lift this restriction. For the restriction to lift Respondent shall satisfactorily demonstrate to the Board that she has remediated her knowledge deficits in the area of intra-atricular injections.

b. Respondent shall obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in pharmacology. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license. The probation will terminate when Respondent supplies proof of course completion satisfactory to Board Staff.

3. Board Staff or its agents shall conduct a chart review at the conclusion of one year from the effective date of this Order. The Board retains jurisdiction to take additional disciplinary or remedial action based upon the results of the chart review.

4. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

5. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

## RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that she has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-102. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 9th day of June, 2006.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 9th day of June, 2006 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Certified Mail this 9th day of June, 2006, to:

Jeri B. Hassman, M.D.
Address of Record

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